Executive Summary

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Maintaining access to physician care in a changing health care environment where providers are at greater financial risk has been of ongoing interest to the Maryland General Assembly. Most recently, malpractice premiums appear to have entered the rapidly rising portion of their actuarial cycle increasing to a level of visibility not seen since elevated malpractice premium issues surfaced in the mid-1990s. Across the nation, an increased prevalence of managed care appears to have reduced charity care and services to Medicaid patients in physician offices. Physician real incomes (adjusted for inflation) have seen modest declines and physician willingness to accept indigent or low-paying patients has weakened. These same trends appear to be playing out in Maryland.

The General Assembly response to the more difficult financial environment for providers has been to regulate billing and payment practices. Although the prohibition on physician balance billing of HMO patients is a key consumer protection, legislation passed in 2000 required HMOs to pay nonparticipating physicians at least 125 percent of the rate paid to participating physicians. House Bill 805, passed in 2002, clarified the geographic areas over which the 125 percent threshold was calculated. In 2003, Maryland expanded support to trauma physicians by establishing an uncompensated care pool for physician trauma care. These measures addressed pressing problems, but the Legislature also recognized that broader problems existed. House Bill 805 required the Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC) to study issues affecting health care provider reimbursements by private and public payers and self pay patients in the state. The commissions completed five studies to meet the requirements of the law; brief summaries of each report follow.

Study #1

Adequacy of Payments Relative to Costs and Implications for Maryland Health Care Providers. The first study examined payments relative to fully allocated overhead costs for the years 1999 through 2002. The report found that payments from private payers in Maryland and Medicare were adequate in covering the fully allocated overhead costs of care.[1] The ratios of private payment to allocated costs were lower than the U.S. overall, due to comparatively lower private sector payments per unit of care. On average, Medicaid payments were just sufficient to cover overhead expenses. However, Medicaid payments were not sufficient to cover overhead expenses on average for tests, imaging services (radiology), and technical procedures (surgeries).

Private sector payments are currently adequate to fully cover allocated operating costs for a typical private practice with average overhead expenses, but this study found that private and Medicare payment levels do not offer sufficient surplus to cross-subsidize Medicaid services at current levels. At best, MHCC expects the underlying costs of care will remain stable and, at worst, to increase in the near future along with the rising cost of labor and malpractice premiums. Should payments remain essentially stable and possibly decline in terms of "real dollars," providers, especially those with high Medicaid and uncompensated care patient shares, may face increased financial pressure since payer mix is critical in determining if total payment is sufficient to meet overhead expenses.

[1] Fully allocated overhead expense includes practice expense and professional liability expense. Practice expense includes nursing and administrative staff wages and fringe benefits, medical supplies, and office rent and related costs.

Primary care providers that perform relatively few high value procedures will experience high financial pressure if payments and practice expense continue current patterns. University-based practices that serve as the providers of first and last resort to the uninsured and Medicaid populations will continue to face challenging circumstances as they balance multiple priorities of treating patients, medical education, and clinical research. Practices with disproportionately high shares of uninsured and Medicaid patients may face similar dilemmas.

This report examines the payment levels of non-physician providers (NPP) relative to physicians. The limited information currently available about the practice costs of non-physician practitioners makes a precise estimate more difficult, however these providers generally face lower malpractice insurance costs than physician counterparts. By contrast, an analysis of payment shows that private payers typically reimburse non-physician practitioners modestly to substantially below the level paid to physicians. This is largely in contrast to the Medicare payment policy where, with a few notable exceptions, Medicare pays the same rate to all providers qualified to provide a given medical service.

Despite an increased financial stress on providers, trends in physician supply do not give cause for immediate alarm. Maryland appears to have an adequate supply of physicians compared to its neighboring states although practices willing to accept Medicaid patients or those without insurance are likely to be in shorter supply. Physicians' incomes in Maryland appear to be competitive with those available in neighboring states. ***Over time the cumulative impact of declining real payments (adjusted for inflation) and increasing operational costs, particularly malpractice expense, to practice could pose serious consequences for the availability of services and patient access to care. An expansion of commercial insurance coverage coupled with increased levels of public funding for Medicaid and Medicare would ease the need for providers to count on a cross-subsidy from private insurance.***

Study #2:

***Feasibility of Designing a Payment System that Establishes Minimum and Maximum Payments*.** The second study examined the potential for implementing a uniform payment system. A payment system for physicians and other health care professionals based on the structure used by Medicare was abandoned by the Health Care Access and Cost Commission in 1997 (HCACC) after a 3-year development effort. At the time the HCACC, a predecessor to MHCC, determined that further development of the payment system had little support from providers or payers. HCACC decided that enhanced competition appeared to have contained costs in the marketplace without implementing the payment system and concluded that fee-for-service was on the decline. At the end of the development effort, the HCACC concluded that a payment system would not create a broad basis for systematically comparing fee-for-service and capitation arrangements. Finally, implementation of such a system would be disruptive to carriers and providers, particularly smaller practices.

The health care market has changed since 1997. A strong trend towards consolidation exists in the payer sector with six payers currently controlling 95 percent of the Maryland market. Declines in tightly managed care have brought the privately insured HMO market share down to about 35 percent from the 50 percent range in 1998. Five of the six major payers in the State offer a full range of products with product selection dependent on purchaser (employers) and consumer willingness to pay. Payer dependence on any particular delivery system has declined. The use of

capitation is down, but as noted previously, provider expense is rising and reimbursement is nearly flat across payers.

Despite the changes since 1997 MHCC cannot identify significant support for resuming development of a payment system. Although the market has changed, it has not changed sufficiently to warrant reconsideration of a payment system. Many of the roadblocks that stalled the previous system still exist. First, technology limitations remain; the expense of implementing the Health Insurance Portability and Accountability (HIPAA) Administrative Simplification requirements was significant for most providers and initiating a new payment system on top of the federal requirements would further the technological burden. Second, a payment system based on per unit prices will not solve issues of uncompensated care or offer an effective tool for cost control. The Centers for Medicare and Medicaid Services (CMS) has found that the physician fee schedule, while effective in making payment more equitable across specialties, does not contain explicit cost control mechanisms. CMS has developed controversial and complex update processes, each of which has produced significant volatility in reimbursement. It is likely that Maryland, using a similar system of payment, would face the same problems. A major unresolved issue in the earlier effort was how to fund uncompensated care; no solution was devised. As a final point, the administrative costs associated with payment system implementation are significant for the public and private sectors. ***The study concludes that the limited use of payment floors and ceilings may be appropriate to signal the appropriate level of payment for services when multiple stakeholder interests conflict, such as setting floors for non-participating providers that serve HMO patients.***

Study #3

Estimating the cost of uncompensated care for hospital and university-based providers and the feasibility of establishing an uncompensated care fund for these providers.[2]

This study examined the more narrow issue of developing a pool for the providers that absorb a significant share of uncompensated care – hospital and university-based physicians. The analysis was limited to uncompensated care expenses associated with uninsured patients.[3] Study findings show that the cost of reimbursing all uncompensated care for hospital and university-based physicians at 100 percent of Medicare was approximately $40 million in 2001 dollars. University-based physicians accounted for about 25 percent of total uncompensated care expenses.

Identifying a revenue source to support the subsidization of a physician uncompensated care program would be challenging, particularly with the fiscal constraints that Maryland is now facing. The following revenue sources have been, or are being, considered for future use by other states to fund physician uncompensated care: automobile registration, assessment on penalties and fines for moving violations, tobacco tax revenue, surcharge on residential telephone calls, tobacco settlement revenue, and state general fund revenue. These sources of revenue offer possible sources for funding a pool in Maryland.

[2] HSCRC, ***Feasibility of Establishing a Hospital-based and University-based Physician Uncompensated Care Fund,*** Baltimore, MD 2003.

[3] Although the previous study suggests that the Medicaid underpayments are significant, this analysis did not estimate the Medicaid shortfall.

Study #4

Feasibility of including hospital and university-based physicians in the HSCRC hospital rate setting system.[4] A renewed interest in possibly including physicians in the hospital rate setting system reflects rising provider practice expense, tightening third-party payment, and increasing levels of uncompensated care. Uninsured patients are rarely, if ever, able to pay their medical expenses following hospitalization, which means the rendering physician and the hospital received little or no reimbursement for services rendered to the patient. Maryland's Hospital All-Payer Rate Setting System permits hospitals (but not hospital-based physicians) to equitably recoup the reasonable cost of delivering care to the uninsured. This disparity is a major issue to physicians who that are also obliged to treat, but unlike hospitals receive no protection from the State.

The original HSCRC statute gave that commission authority to regulate physician rates if the physician was compensated by the hospital, but it did not give HSCRC the authority over physicians directly billing patients. HSCRC sought authority to expand the rate system to regulate direct billing physicians in 1977. In a pivotal suit (Holy Cross Hospital v. HSCRC 283 Md 677, 393 A.2d 181 (1978)), the Court of Appeals ruled that HSCRC did not have the authority to regulate direct billing hospital-based physicians. Lacking the authority to regulate all hospital-based physician services, the HSCRC sought to eliminate its authority to include hospital-based physician expense costs in the rate setting system. Legislative action in 1985 removed costs associated with physician treatment of individual inpatients or outpatients, otherwise known as "identified physician costs," from the HSCRC's rate setting authority. Under current law, hospital-based physician expenses are not included in hospital rates approved by HSCRC.

Some, but not all, of the criteria needed to trigger state intervention in physician rate setting are present today. Previous reports required under HB 805 have documented inadequate payment levels for some services and some inequities in reimbursement. Other reports completed by the commissions have documented rising numbers of uninsured patients.[5] Some requirements needed to launch a payment system are missing. In particular, an equitable system of payment would require the collection of audited, detailed, and timely financial and patient acuity data from the regulated entity to determine standards of reasonableness for rate setting. In the past, the hospital-based physician community had been reluctant to provide such data and to participate in a statewide system that *establishes a ceiling payment for services based on reasonable reported costs.*

Maryland's hospital rate setting system is governed by the Medicare waivers set forth in the Social Security Act (SSA). A more formidable barrier to implementation is the need to obtain an expanded waiver from CMS for even a limited expansion of the hospital rate setting system. Because this waiver appears under the Part A Section of the SSA, the current waiver applies only to inpatient hospital services as defined under Section 1816(b). Section 1816(b) explicitly prohibits payment under Part A for physician services except for the reasonable costs of residents and interns and physician costs in hospitals wherein all physicians have agreed to forego Part B billing for Medicare services. Inclusion of physician services could require a change in federal

[4] HSCRC, ***Feasibility of Including Hospital and University-Based Physicians in the Hospital Rate Setting System***, Baltimore, MD 2003.
[5] MHCC, ***Health Insurance Coverage in Maryland Through 2002,*** Baltimore, MD 2003.

and state laws. It should be emphasized that CMS has not granted a waiver for more than twenty years.

Given the absence of broad-based support from the provider community, the difficulty in obtaining CMS approval for a waiver expansion, and the parallel and real risk to the waiver during a review process, it is not feasible to incorporate hospital and university-based physicians into the hospital rate setting system in the near future.

Study #5

Study of the Balance Billing Prohibition in Maryland. The final report examines the issue of whether the State should maintain a prohibition against the balance billing of HMO subscribers for covered services provided by non-participating providers. Balance billing is a term used by the insurance and provider community which is defined as the practice of a health care provider billing an HMO member for an amount of the provider's charges not covered by the insurer. Under Maryland law, providers under contract with HMOs (participating providers) as well as non-participating providers may not balance bill HMO members or subscribers for covered services. However, insurers are required to reimburse non-participating providers at a certain rate for covered services, as defined in Maryland statute (§ 19-710.1 of the Health-General Article). In addition, all providers may fully bill HMO members for non-covered services (§19-710(i) and (p) of the Health-General Article).

This report provides an overview of the Maryland law since the inception of "enrollee hold harmless" legislation over 15 years ago and features results from a survey of individual states' balance billing laws and regulations. Specific issues relating to Maryland's balance billing prohibition are discussed and the prohibition's impact on health care delivery is analyzed. The impact on hospital-based physicians of federal EMTALA requirements and balance billing prohibitions are discussed. ***The report outlines possible refinements to Maryland law that would provide greater clarity on the level of reimbursement when non-contracting physicians render care to HMO patients. However, the MHCC makes no recommendation on whether the prohibition against balance billing should be abrogated. Neither consumers nor the physicians may have a choice of receiving or giving treatment in emergencies. Changes to balance billing prohibitions alone will not remedy the financial stress of hospital-based physicians. High uncompensated care volumes and low Medicaid reimbursement levels are more pressing issues. Progress in addressing uncompensated care through coverage expansions and the establishment of an uncompensated care fund would be more effective approaches to stabilizing reimbursements to critical hospital-based providers.***